PIPADOR REVISION

MRCOG Part 1 Revision Notes

Faecal Incontinence

CLINICAL MANAGEMENT • LECTURE 497

VISUAL EXAMINATION REVISION NOTES

2026 Edition

497

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Faecal Incontinence

Definitions, causes, assessment and management of faecal incontinence (NICE CG49)

OASI	Loperamide	Biofeedback	SNS
Commonest cause in women	First-line drug	Specialist conservative	Sacral nerve stimulation

■ KEY FACTS: Learning objectives

- Define faecal and anal incontinence, urge and passive incontinence.
- Describe causes and assessment, including endoanal ultrasound and manometry.
- Describe initial, specialist and surgical management (NICE CG49) and prevention after childbirth.

497.1 Key definitions

Term	Definition
Faecal incontinence	Involuntary loss of liquid or solid stool that is a social or hygienic problem
Anal incontinence	Involuntary loss of flatus, liquid or solid stool
Urge faecal incontinence	Leakage despite trying to hold on (EAS weakness)
Passive faecal incontinence	Leakage without awareness (IAS dysfunction, neuropathy)
Endoanal ultrasound	Imaging of the internal and external anal sphincters to detect defects
Anorectal manometry	Measurement of resting (IAS) and squeeze (EAS) pressures and rectal sensation

■ IN PLAIN ENGLISH: Faecal incontinence

Faecal incontinence is common, embarrassing and under-reported. In women it is often linked to **childbirth injury** to the anal sphincter. Most improve with **simple measures and specialist physiotherapy**; surgery helps selected women.

497.2 Causes

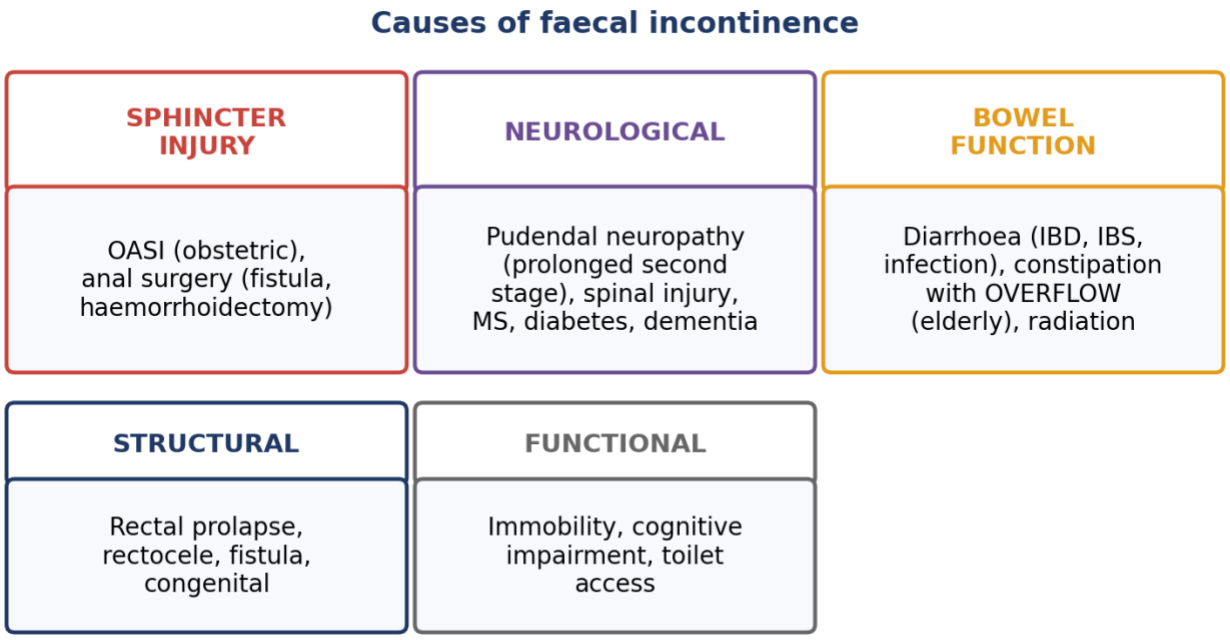


Figure 497.1 — Causes of faecal incontinence

497.3 Assessment and management

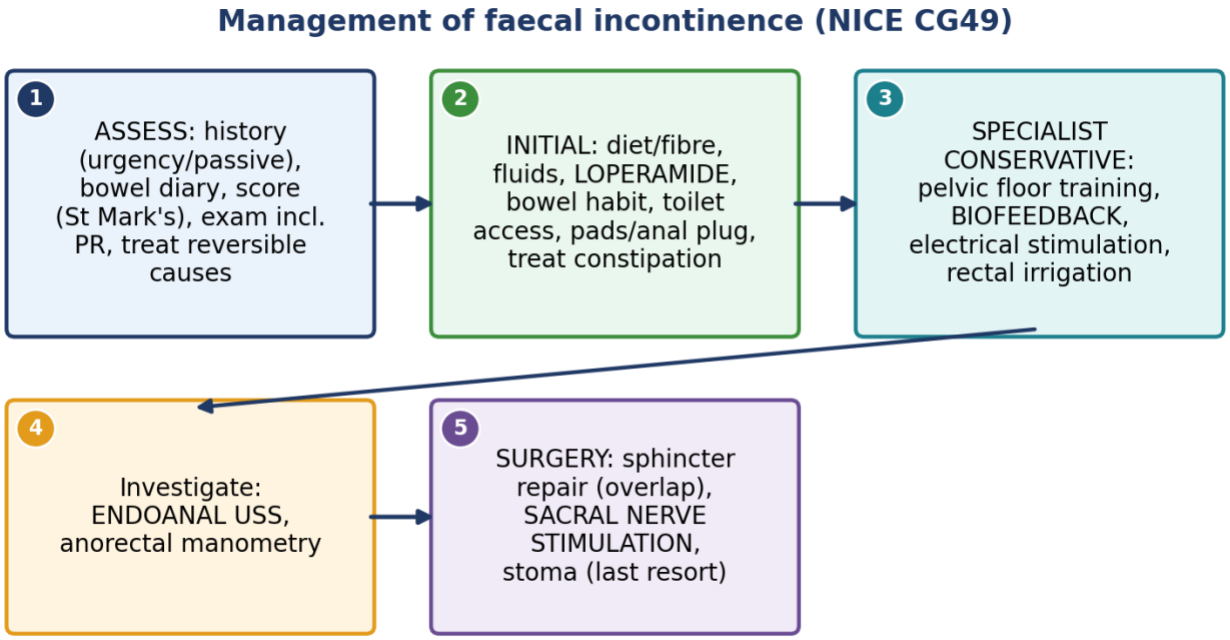


Figure 497.2 — Management (NICE CG49)

Step	Details
Baseline assessment	• History (type, frequency, stool consistency — Bristol stool chart, urgency, passive soiling), impact, obstetric history, medications • Examination including PR (tone, squeeze, impaction, rectal prolapse) • Exclude red flags (rectal bleeding, change in bowel habit, weight loss → colorectal 2WW)

Step	Details
Initial management	• Treat underlying conditions (diarrhoea, impaction/overflow — laxatives first), diet and fibre, fluid • Loperamide (titrate), toilet access, bowel routine, pads/anal plugs, skin care • Psychological support
Specialist conservative	Pelvic floor muscle training, biofeedback, electrical stimulation, rectal irrigation (transanal irrigation)
Specialist investigations	Endoanal ultrasound, anorectal manometry, defecography (prolapse/rectocele)
Surgery	• Overlapping sphincter repair for a defect (results deteriorate over time) • Sacral nerve stimulation (SNS), PTNS • Rectal prolapse repair • Stoma as last resort
After OASI	• Prevention (OASI care bundle) • Immediate recognition/repair • Follow-up at 6–12 weeks • Endoanal USS if symptoms • Counselling about mode of next birth

■ **COMMON PITFALLS**

Missing faecal impaction with overflow in older women.

Not asking about bowel symptoms after OASI.

Missing colorectal cancer red flags.

497.4 Must-know summary

■ **EXAM TIP**

- Faecal incontinence = involuntary loss of stool; anal incontinence includes flatus.
- Causes: OASI/sphincter injury, neuropathy, diarrhoea, overflow constipation, rectal prolapse.
- Initial: treat cause, diet, loperamide, toilet access, pads; specialist: biofeedback, PFMT, irrigation.
- Investigate with endoanal USS/manometry; surgery: sphincteroplasty, sacral nerve stimulation, stoma last.

■ **MNEMONIC / MEMORY AID**

FI ladder — 'Fix the stool, Feed the floor (biofeedback), then Fix the sphincter/nerve'.